BEFORE THE INDUSTRIAL COMMISSION OF ARIZONA

PUBLIC HEARING REGARDING "PROCESS FOR STREAMLINING THE AUTHORIZATION PROCESS FOR TREATMENT THAT IS WITHIN THE EVIDENCE-BASED TREATMENT GUIDELINES"

Phoenix, Arizona
August 17, 2017
1:00 p.m.

APPEARANCES:

Dale Schultz, Chairman
Joe Hennelly, Vice-Chair
James Ashley, Director
Jason Porter, Chief Legal Councel
Robin Orchard, Commissioner
Steve Krenzel, Commissioner

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PROCEEDINGS

17:00:00 CHAIRMAN SCHULTZ: We have reached the appointed time. I'd like to call this meeting in the Industrial Commission to order. I'd like to start the meeting with the Pledge of Allegiance.

13:01:12 (Pledge of Allegiance.)

CHAIRMAN SCHULTZ: Now I'd like to have introductions here so that you all know. We won't extend it to all of you folks, but at least so you'll know who is up

13:01:28 here. I'm Dale Schultz, and I'm Chairman of the Industrial Commission.

MR. HENNELLY: Joe Hennelly, Commissioner.

MR. KRENZEL: Steve Krenzel, Commissioner.

MR. ASHLEY: James Ashley, ICA Director.

MS. ORCHARD: I'm Robin Orchard, Commissioner.

MR. PORTER: Jason Porter, Chief Counsel.

CHAIRMAN SCHULTZ: Great. Thank you.

Our first order of business today is to have this public hearing at which we are discussing the issue of streamlining the authorization process for treatment that is

13:01:58 within the evidence-based treatment guidelines.

By way of a summary in April of 2012, Arizona lawmakers passed House Bill 2368, which required the Industrial Commission to develop and implement a process for the use of evidence-based treatment guidelines where appropriate to treat injured workers. With significant input from stakeholders, the Commission developed and implemented a
13:02:29 series of 12 rules published in Title 20, Chapter 5 of Arizona's Administrative Code.

Among other things, the treatment guidelines prescribes a limited use of evidence-based treatment guidelines as a tool to support clinical decision making and quality health care delivery to injured employees within the context of the Arizona Worker's Compensation System. It adopted Work Loss Institute's Official Disability Guidelines,
13:02:58 ODG, Treatment and Worker's Compensation as the standard reference for evidence-based medicine.

It limited the applicability of ODG to the management of chronic pain and the use of opioids for all stages of pain management. It outlined a noncompulsory process for a medical provider or injured worker to seek preauthorization from a payor for medical services for treatment, established an administrative review process to
13:03:29 help resolve disputes between medical providers, injured employees, and payors, and outlined procedures for bringing unresolved disputes to the Industrial Commission for hearing.

Under the treatment guidelines, medical providers are committed to seek preauthorization from a payor for medical treatment or services for an injured worker. Preauthorization requests must be in writing and may be submitted my mail, electronically, or by fax directly to a payor. When a preauthorization request is properly submitted, the payor is required to respond within 10 business days. A payor may respond by communicating its preauthorization decision to the provider or notifying the provider that an IME, an independent medical evaluation or exam, has been requested under Arizona Administrative Code Section 20-5-114.

When a payor requests an IME, the time for rendering a preauthorization decision is suspended. In these circumstances, the payor's decision on a preauthorization request must be issued no later than 10 business days after the final IME report has been received by the payor. If a payor does not communicate its preauthorization decision within 10 business days, the payor's nonaction is deemed a no-response, and the provider or injured employee may bypass the reconsideration process and immediately request administrative review from the Industrial Commission.

Administrative review is a process that includes a peer review of the requested treatment or services. The administrative review process is expeditiously administered

by the Industrial Commission's medical resource office. The payor is responsible for paying the cost of the peer review.

Following the issuance of the administrative review determination, an interested party, which includes the employer, employee, and insurance carrier or their representative, who is dissatisfied with the administrative review determination may request that the dispute be referred to the Industrial Commission's Administrative Law Judge Division for hearing. Parties may elect to participate in a fast track ALJ dispute resolution program designed to expedite review of contested cases.

13:05:58

Section 5 of Senate Bill 1332 of the 53rd Legislature, First Regular Session, directed the Commission to review and determine a process for streamlining the authorization process for treatment that is within the evidence-based treatment guidelines. The Commission is required to complete the process on or before December 31, 2017.

13:06:27

We now welcome you to present your oral comments regarding your concerns with the current authorization process and suggestions for streamlining the process for treatment that is within the evidence-based treatment guidelines. Those wishing to speak may do so by filling out a speaker's slip, which is available at the door. I will call each speaker who will have five minutes to speak,

13:06:57

thereabouts. It depends upon the number of speakers. If we can allow additional time and that additional time is necessary, then we will permit some additional time, but I
13:07:28 reserve the right to hold your comments to five minutes per person.

Although the public hearing will end when oral comments have concluded, written comments will be accepted through Friday, September 15. Friday, September 15. So there is considerable additional time for you all to submit
13:07:55 and for anyone else to submit written comments. The Commission will carefully consider all written comments along with your oral comments. The Commission will discuss and take action on the issue at a future regular public meeting of the Commission.

Please keep in mind that this oral proceeding is for the Commission to receive public comment on the issue of streamlining the process for treatment that is within the evidence-based treatment guidelines. If you have questions regarding the treatment guidelines, the Commission has posted
13:08:30 an extensive list of frequently asked questions on the Commission's medical resource office website.

In the event that the F.A.Q.s do not answer your questions, we would invite you to submit questions directly to Jackie Kurth, manager of the medical resource office. Ms. Kurth's e-mail address and phone number are available on

the Commission's website.

With that, we now open the floor to public comment, and I would ask each of you as a speaker to please introduce yourself and indicate who you are representing for the purpose of our record of the proceedings.

13:08:58

Our first speaker is Randall Prust, M.D.

Dr. Prust, welcome.

DR. PRUST: Thank you very much.

13:09:30

So I am Randy Prust. I am a board certified pain management specialist in Tucson, Arizona representing Rincon Pain Management. I was one of the six physicians that was appointed by Laura McCrary to the physician advisory board that made suggestions to the actual board that would make a final decision on which guidelines would be adopted. The six physicians all voted against ODG, and part of it was because

13:10:00

of this authorization process.

Ken Eichler is the CEO of ODG, and he came and talked to us a number of times. Most of his talks were about the success stories about using and implementing the guides and how this was done successfully in other states. The State of Arizona ultimately decided not to adopt those

13:10:27

recommendations of Dr. -- or Mr. Eichler. Specifically, the evidence-based medicine guidelines that -- let's just take my example of, let's say, an epidural steroid injection. There is a section, and it's evidence-based medicine on the

criteria the patient needs to meet in order to qualify for that procedure.

There is a separate section, the Utilization Review Advisement, which was not adopted by the State, but recommended by Mr. Eichler, because this takes out the authorization process when the patient meets all that criteria, so you don't incur that 10-day delay or more. It gets the patients -- Mr. Eichler showed that patients get back to work faster, because they get treatment earlier. They have better outcomes, and of course, the cost is less.

13:10:55

So I'm suggesting that you use this evidence-based medicine portion of the guidelines, the Utilization Review Advisor. It's very easy to use. If the patient meets those criteria and then you look up the procedure and diagnosis, it will have a colored box. The only one I'm interested in today is the green box. The green box is an automatic "go." The others, "yellow" as an example, we would require some more utilization review, and then there is a black box.

13:11:28

So there's different colors that definitely you would have to contact the adjuster and work it out, but for those procedures, where the doctor has determined that they meet all the evidence-based medicine guidelines, I would suggest using that utilization review advisor that the ODG already has in their framework. So use that total package as part of the streamlining of the authorization process. Thank

13:11:59

you.

CHAIRMAN SCHULTZ: Any questions for Dr. Prust?

13:12:30 Okay. Thank you very much.

Our next speaker is Kris Yonker, is it?

MR. YONKER: I signed up for one of the other agenda items.

CHAIRMAN SCHULTZ: Oh, okay. We will be continuing our meeting upstairs, third floor, and you all are invited if

13:12:58 you wish to join us for the rest of our agenda.

MR. YONKER: Okay.

CHAIRMAN SCHULTZ: We will see you upstairs. Thank you.

David Danowski?

MR. DANOWSKI: I'm with Kris.

CHAIRMAN SCHULTZ: Same? Okay. We are getting through this stack in a hurry here.

David -- is it -- what do you think, Robin?

MS. ORCHARD: Parker.

13:13:29 CHAIRMAN SCHULTZ: Dave Parker. I've heard of you.

MR. PARKER: I guess my handwriting needs a little more work, too.

CHAIRMAN SCHULTZ: Yeah, well, it's me, too, Dave. Sorry.

MR. PARKER: Thank you, Chairman Shultz, Commissioners, Director Ashley, for the opportunity to

provide my thoughts on a topic that is of statewide significance to employers, employees --

CHAIRMAN SCHULTZ: For the record, you're David Parker and --

MR. PARKER: David Parker, representing myself.

CHAIRMAN SCHULTZ: Thank you.

MR. PARKER: Of significant statewide interest to

13:13:59 employers, employees, insurers, and even the Special Fund.

My name is David Parker. I speak today from the perspective of a risk management practitioner, worker's compensation administrator, regulator, insurer, industry association member, and at times, injured worker. I will keep my comments to the conceptual and policy level and leave specific application to those who work in the process daily and administer claims daily.

The objective of post-injury medical care is to

13:14:29 return an injured employee as far as possible, as fast as possible. The objective has additional benefits of helping to manage costs, but the best outcome possible is what we're looking for.

There is a general recognition that worker's compensation contains significant frictional costs and delays, much of it caused by disagreements on compensability or treatment plans. The uncertainty and extremely long tail

13:14:56 and claim costs exacerbates this issue, and as you're reading

the process, we can see that we have this piece of time, and then you have this piece of time, and this piece of time, and it's conditioned upon which parties can agree to play, so it delays the care and ultimately the outcome.

While most claims resolve quickly with little cost, only 10 percent of the claims that will eventually reach the excess insurer level were identified early on as catastrophic claims, and 90 percent of the claims that will ultimately get to excess layer were never identified as claims that were likely to become bad. They just never resolved.

13:15:29

A full five years will pass before insurers receive notification of just 50 percent of the claims that will ultimately get to their layer. So it's an issue that's important for the injured worker, who has got a claim that's continuing, and the payors, who are trying to resolve those claims.

The general tenet of worker's compensation is that we take employees they way that we find them. Some will be more fragile than others, some will be more resilient. Employees come with all types of comorbidities, that while they are not the responsibility of the employers or worker's compensation insurer, will influence the extent of injury and recovery from that injury.

13:15:58

Evidence-based medicine is founded on peer review research that has documented effective treatment protocols

for specific conditions and injuries. The guidelines
13:16:26 document what works well for many people, hopefully most people, and provides reasonable expectations and rehabilitation and recovery. Because of the length of time that it takes to perform and publish peer-reviewed research followed by the time until that research is reviewed and incorporated into updated guidelines, E.B.M. guidelines may lack the most current science and medicine. So E.B.M. guidelines provide a body of consensus, but they are not exhaustive in their content.

I would like to use an analogy. In the same way
13:17:00 that in education we teach the way that most students learn, but not all students, E.B.M. documents what works well for most people, but not all people.

Essentially, E.B.M. says that if an injured worker has a specific diagnosis, then a defined range of treatment should result in a certain prognosis or outcome. Employees should not languish in their care or recovery. I think we've all seen ones that just hung on so long you wondered why.
13:17:30 That should not happen.

The logical corollary to E.B.M. suggests that an employee who is not progressing, may have an incorrect diagnosis or unidentified comorbidities, or this employee may just not respond well to that treatment or that range of treatment.

So in the same way that a teacher must identify another way for some students to learn, the system, including physician, patient, employer, and insurer, must have a means to identify early the treatment isn't working for this employee and to identify a plan that will succeed.

We must also recognize that science and medicine will not progress if everyone keeps doing just the same old thing, even if that seems to work well for most. Treatment recommendations in the guidelines should not be the only authorized path of care.

However, the guidelines have proven to be effective for most people. While not necessarily presumptive, the approval process for care consistent with the guidelines should be as streamlined or automatic as practicable. The guidelines become a tool comparing an employee's progress to expectations, helping to insure that the employee's recovery does not languish. If not progressing as expected, the treatment plan should be reevaluated.

When medical providers want to follow another treatment plan, they should document the reason for deviation, the proposed care and expected outcomes, and how they will measure outcome and anticipated cost. Arizona's Worker's Compensation process relies upon good communication, knowledgeable professionals, and a flow that needs to have very little regulatory action. Essentially, we deal with the

exceptions, and those exceptions need to represent a very small percentage.

The E.B.M. approval process should follow the same principles. Almost all treatment that is consistent with adopted guidelines should proceed without need for approval when an injury has been identified as compensable. The process should facilitate communication, and early identification of injured workers who are not progressing as expected. The process should also facilitate agreement on an alternate treatment plan, where conventional treatment has not been effective, or where the physician can reasonably anticipate that the alternate treatment is reasonable, necessary, technically feasible, and cost effective.

A regulatory approval process should resolve conflicts when necessary, but without adding additional burden, delay, or frictional cost to most care. Also, it would be easy to see this issue as just impacting the providers and payers, but injured workers must also have a reasonable opportunity to be heard and participate in the decision-making process.

Ultimately, I am pleased to see the treatment guidelines have been successfully implemented and am looking forward to a broader implementation of treatment guidelines. I think it will be good for all.

I'd like to end with one thing. I had lunch at my

favorite downtown restaurant today, got my fortune cookie, and this is a good one. It says, " A difference, to be a difference, must make a difference." That's what we want with E.B.M. Thank you.

CHAIRMAN SCHULTZ: Thank you, Mr. Parker.

Questions for Mr. Parker? Okay. Thank you.

MR. PARKER: Thank you.

13:20:53 CHAIRMAN SCHULTZ: Cathy Vines.

MS. VINES: Good afternoon. Cathy Vines with Copperpoint. First, good afternoon, Chairman, Commissioners, Director Ashley.

I'd like to add my own personal support to the 13:21:30 comments that were submitted by Todd Lundmark, fellow committee member for those many months and evenings, where we had some lively debate and dialogue as to the necessity for evidence-based medicine. That was after we identified what evidence-based medicine even was, how it could benefit Arizona, and then ultimately the arduous process of 13:21:59 developing a process and a form and a system. I can agree with Todd. We did have debates about automatic authorizations. As a group, we did not feel that that was the approach that was necessary to take at that time.

I don't know that we have evidence that says anything has changed since then, so personally, my support for the comments that were submitted by Mr. Lundmark.

13:22:28 I am here this afternoon representing collective comments that were submitted earlier today to the Commission by a group of business and industry stakeholders. We, as a group, appreciate the opportunity to provide a unified business and industry perspective on this most important issue.

The inclusions of the provisions in Senate Bill 1332 13:22:58 was really in response to concerns raised by some of the stakeholders involved in our process with the intent that the process could be improved. We're offering the following concepts and do believe that there is an opportunity to enhance the existing process.

First, we would request that providers requesting 13:23:27 authorization be required to do so, required to do so, using a standardized, simplified form. Currently, the requests for authorization come to payors and adjustors in a variety of formats. Sometimes there is a fax. Most often, it's included within page 5, 6, or 7 of an electronically generated medical report. Adjustors may not necessarily see 13:23:59 these routine medical reports as a priority document. So we would suggest that a standardized form would more easily be identifiable as a priority, and the issues could be addressed in an expedited fashion.

Secondarily, we would request that the number of mandatory fields that exist in the current commission form be

13:24:28 reduced. There are some that are probably of minimal administrative benefit, but really do not work to expedite the process, so review and development of a simplified form would be recommended.

Lastly, if the commission were to require the use of a standardized, simplified form, we would support shortening the time period that the payor or the adjuster has to respond 13:24:57 to this request from the current 10 days to a 7-day period.

CHAIRMAN SCHULTZ: Cathy, would that be business days or calendar days?

MS. VINES: I would suggest business days.

CHAIRMAN SCHULTZ: Thank you.

MS. VINES: We would also note that what is currently referenced in the statutory directive applies only to the authorization process associated with treatment that 13:25:30 is within the evidence-based treatment guidelines, pursuant to the rules that you have referenced. We would support and think it's a reasonable time period currently, to expand the applicability of the treatment guidelines to address the additional body parts and conditions.

Were the Commission to proceed with this consideration of this issue, each of the undersigned, the group that is supportive of these recommendations, would be 13:25:58 able to produce material and detailed information supporting the proposition to expand, and then indicating that this will

improve medical treatment for injured workers, make treatment and claims processing more efficient and more cost effective, and if the guidelines, and the fact that the guidelines do adequately address many additional body parts and conditions.

We consider implementation of evidence-based
13:26:28 medicine guidelines within the worker's compensation system to be essential to the sustainability of our system that improves medical treatment to injured workers in an efficient and cost-effective fashion.

To the extent that certain stakeholders have raised issues regarding the authorization process, we do believe that the suggestions that I've mentioned today, certainly do address these concerns. The guidelines do address the
13:26:59 additional body parts and conditions that we all frequently see in worker's compensation injuries, and we would all welcome the opportunity to provide additional comments in support of expanding the treatment guidelines. Thank you.

CHAIRMAN SCHULTZ: Thank you. Questions?

MS. ORCHARD: Thank you for your perspective. Cathy, I have a question, and I feel like I should know this. I'm sorry, but I don't. Is there a current form that you'd like to see streamlined, or would you like to see development
13:27:29 of a brand-new form?

MS. VINES: Probably the best answer is both. If we are looking at expanding the process and the rule and the

applicability, I would recommend a review of the existing form. If we're looking at assisting in authorization of routine treatments that are not currently part of the form, I would suggest that it would be helpful for the Commission to publish a form, very simple, certainly not as complicated as what is out there, because adjustors do get this information in various forms and fashions now. It just isn't always recognized in document management systems or mailrooms as something that was urgent, expedited, and there is a time frame from which to respond.

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MS. ORCHARD: So, currently, the Commission does not have a standardized form?

MS. VINES: The current Commission I do not believe has a form for authorizations beyond the chronic pain and opioid narcotic medication.

13:28:30

MS. ORCHARD: Thank you.

MR. PORTER: Commissioner Orchard, the MRO office does have a form. It's the MRO-1 form. As Cathy indicated, it was designed for the process as it exists now and the scope that it exists, so it does only pertain to pain management and the use of opioids and all, but that form is not required to be used. While the Commission in its F.A.Q.s has strongly encouraged providers to use that form, for some of the reasons that Cathy has outlined, our rules don't mandate its use.

13:28:56

CHAIRMAN SCHULTZ: And explicit in your recommendation is that this would be a mandatory form? If you are going to be reducing --

MS. VINES: Yes. I believe that we do need a mandatory form, and yes, support it for the reduction of the number of days down to the 7 from the 10.

13:29:29 CHAIRMAN SCHULTZ: Thank you.

MS. VINES: Thank you.

CHAIRMAN SCHULTZ: Any other questions? Thank you, Cathy.

Debra Runbeck.

13:30:01 MS. RUNBECK: Mr. Chairman, members of the Commission, Director Ashley, Mr. Porter. My name is Debra Runbeck, and I am here speaking on behalf of the Arizona Association of Lawyers for Injured Workers. Thank you very much for inviting us all to be here today. We appreciate the opportunity.

This is an important topic for everybody concerned. The ICA had previously adopted the guidelines with the stated 13:30:28 intention of providing a more efficient method of getting appropriate medical care to injured workers. Along those lines, it's crucial to get a rapid response to a doctor's request for authorization for treatment.

Many of the insurers now use the ODG under all circumstances to either authorize or deny treatment. The

problem that's being encountered is that many times the treating doctor might request something that actually falls within the ODG guidelines and is appropriate under those
13:31:00 guidelines, but they don't get a response to their authorization request.

Often they'll wait a month or so with no response until after repeated requests the treatment is finally approved, which basically leaves the injured worker for that amount of time without any treatment and possibly a worsening condition. Often other times, they make their requests repeatedly over the course of several months only to have it eventually denied. At that point, a request for hearing must
13:31:29 be filed, and that often takes six months or more. All together, that can leave the injured worker going for eight months or more without any treatment. Again, not good for the worker, not good for the carrier, and not good for the ICA.

One suggestion that we had, which has been echoed by a few other people here to ameliorate this problem is to incorporate a provision of rules that would provide the
13:31:57 carrier with a window of we'd say five business days, certainly, that's something that could be discussed, to consider a request. They can still deny the request, within an indication of why they are denying it, if it's under the ODG, or they can authorize it, but if they don't respond at

all within the given time frame, and it's under the ODG, then it would be considered automatically authorized. This would result in quicker care for the injured worker, and it would still follow the recommendations of the ODG, which was the intent and hope of the Commission in adopting these.

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Referring to Cathy Vines, her suggestions for the standardized form I think are good. You know, we can certainly discuss how that would play in and could be incorporated into the auto authorization idea.

Over the past few years, the stakeholders in this system have generally had great success in working together and coming up with solutions that everybody can live with. We would respectfully request that the current effort would follow that procedure, and ask that -- you've already indicated that there will be additional time to submit written suggestions, and we would ask that there be allowed enough time for the stakeholders to have some meetings and see if we can come up with something that everybody can be happy with.

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We would love the Commission to be involved in these meetings and would certainly be happy to keep you advised as to when those meetings are held and have ICA input into it, also.

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Thank you very much for allowing me the opportunity to speak. I'll be happy to take any questions.

CHAIRMAN SCHULTZ: Questions?

MS. ORCHARD: Thank you for your time. This might be a question for both you and possibly Dr. Prust. I know of an example where a medication such as Wellbutrin is in the formulary both under green and under red. It's under green 13:33:59 for depression, if that is related to the worker's comp injury, but it's under red for pain.

So what solution would you have in terms of you requesting auto auth, because it's under green, but it would be probably ordered, in this case, for pain, which would be red?

MS. RUNBECK: That probably is better addressed by Dr. Prust, because the doctors have certainly become more familiar with the guidelines. My knee-jerk reaction would be 13:34:22 that if it falls within the guidelines of recommended use for it, then it would be subject to the auto authorization. Obviously, if it's not under the recommended use for it, then it would have to be considered whether it's appropriate anyway.

MS. ORCHARD: So that could be accomplished in the form, a section of the form?

MS. RUNBECK: Yes.

MS. ORCHARD: Okay. Thank you.

MS. RUNBECK: Anything else?

CHAIRMAN SCHULTZ: Yes. I actually have two

questions, and then Dr. Prust, if you would like to address the question Commissioner Orchard asked.

13:35:00 My two questions are, it appeared that many of your comments were sort of directed at what the processes will look like if the ODG is expanded beyond it's current for pain management and use of opioids. Am I correct in assuming that

13:35:29 you sort of were looking a bit ahead?

MS. RUNBECK: I apologize if I gave that impression. We are certainly not recommending that they be expanded at this time. We do think that we need more time with it in trying to streamline the process before it would be expanded to anything else. This would basically be designed to help with the problems.

Many, many, many injured workers are going through pain management procedures, and you know, they are into that

13:36:00 chronic pain area already. So it's a very, very common problem to be dealing with. So many of the procedures that are being requested fall within the ODG guidelines for the pain management.

So our suggestion would be specifically geared toward dealing with pain management and opioid use that we use some kind of an auto authorization when things fall

13:36:27 within those guidelines and they meet the criteria for them.

CHAIRMAN SCHULTZ: Okay. Then my second question is relative to our period of time of September 15. Would that

give you sufficient time to have any meetings you might wish to have before submitting final comments to us?

MS. RUNBECK: I'm looking up at Mr. Kendell, who would obviously be -- and Suzy, who would obviously be involved in the meetings. Just knowing how hard it is to get such a large group of people together within a month, I suspect that thay may not be sufficient. We certainly would like to be able to come up with something that everybody is okay with before presenting it. So in order to have enough time to have everybody get together and be able to hash things out over a couple of meetings, I suspect it would end up running longer than an month.

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CHAIRMAN SCHULTZ: I have concerns about that, I think, as you and I have discussed before. I don't think the Commission -- the Commission has a deadline to take an action, and I don't want to be held hostage to calendars over which I have no control, because I believe in the past those series of those meetings have turned into a series of meetings, because people were not available on common dates.

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So I would encourage you very strongly to do whatever you can to get the group together, whoever you believe you need to meet, and that's another issue is the group seemed to expand over time.

13:37:59

So I believe that September 15 is a fair amount of time, and yes. It puts pressure on you to get together and

meet to give us your written comments or suggestions, but I do very much want to keep the Commission having the ability
13:38:28 to take action as it needs to to meet its legislatively imposed deadline. So please do everything you can to get us that information. Have your meetings before that September 15 deadline

MS. RUNBECK: Absolutely, Mr. Chairman.

CHAIRMAN SCHULTZ: Thank you.

MS. RUNBECK: We are already trying to gather people together and figure out dates and get everybody on the same page for dates. I think that the issue is just going to be
13:38:57 how long it takes, how many of those meetings it takes for us. It's not always an easy sit down, and we all agree, but we are certainly going to work at meeting your deadline. Absolutely.

CHAIRMAN SCHULTZ: Thank you.

MS. RUNBECK: Thank you.

CHAIRMAN SCHULTZ: Dr. Prust.

DR. PRUST: Thank you. Very briefly, so the formulary for the ODG came about like any formulary with United Health Care, Blue Cross Blue Shield. There's not a
13:39:28 lot of evidence-based medicine to it, because the Food and Drug Administration, as an example, has given authorization to use all these nonsteroidal anti-inflammatories, but the guides, half of them are red, half of them are green, and

it's relatively arbitrary, Ken said.

What they've done, though, is made provisions for that. So when you talk about using the antidepressants for pain, with neuropathic pain, there are provisions when you read through the formulary. As an example, if a patient
13:39:59 fails other neuropathic pain agents like Gabapentin, Lyrica, then you can start going to the red drugs, so it does not say you cannot use them. It says, let's go the more traditional route first.

So that's the way the guidelines, that's the way I'm using them, and that's working for me, that's what Ken recommended. So the red doesn't mean absolutely no. It means, you know what, let's start out with what we feel is a
13:40:27 better pathway, and if that doesn't work, then we can go to some of the drugs that are in red.

Does that answer your question?

MS. ORCHARD: It does. Can you speak to, as somebody who's very familiar with worker's compensation and has worked really well within our system, can you speak to the burden that a form -- one single form for authorization, poses for you or not?

DR. PRUST: There's two things. The electronic
13:40:54 medical record is a curse and a necessary evil, and each one is different. I find it on the insurance side, I understand where they are coming from, because when I get records from a

primary care with a different electronic medical record than myself, they are never the same, never. The only thing that's the same is that at least at the end you have the discussion part, and you can go there.

So I think that in the submission of just a single form from every doctor, to have all that information on there and have to transcribe that to another form, and that's -- I mean, that's why my notes are particularly detailed and specifically make sure that I put all the evidence-based medicine criteria into my notes, and I don't know that another form that I have to fill out beyond that is going to really be that much more useful.

So I understand where Cathy is coming from, but I'm not so sure how to come up with a universal form that I could then -- that I would have to fill out, because I've already got all that information in my notes. So it would create another burden for my office and increase our costs also, but I do understand the problem, though. I get it.

MS. ORCHARD: Thank you.

CHAIRMAN SCHULTZ: By the way, Dr. Prust, I want to thank you very much for coming up from Tucson today to talk to us. We appreciate your effort and concerns.

DR. PRUST: Well, I appreciate it. I came up every third Monday for what, two years, three years, Cathy? It was a pleasure. Thank you.

MS. VINES: Mr. Chairman, let me just provide brief clarity. I do not believe that a simple authorization form would need to contain, nor should it contain, all of the clinical findings that would be within an examination report. We really need a single document that comes in code red, says we need "X" treatment authorized, and most of the time we see some of those referencing examination that occurred on 10/1.

13:43:00

So we would not at all be looking for duplication of that, perhaps it even comes with the report, but it's really more a flag to the adjuster that this does contain a request for treatment, should be handled quickly, and certainly can reference MRI dated this date or other documentation that has already been submitted.

13:43:30

MS. ORCHARD: Thank you.

MR. SCHULTZ: Thank you. And, Cathy, by the way, I very much appreciate what you are saying. We have the same effect here. So a medical report comes in. It may be your standard process that it gets attached to a file or filed, if there's a normal file review date coming up. So it might very well be several days or longer before that file gets reviewed unless you have this, the end, and I agree. I would envision this form to be something simple to start the process, and yes. You are still going to have to review other records before taking action. So I believe I understand the scope of what you are proposing.

13:43:55

13:44:28

MS. VINES: Thank you.

CHAIRMAN SCHULTZ: Any other questions? Okay. Great. Having received no other slips requesting the opportunity to speak, this will conclude the public hearing concerning the issue of streamlining the authorization process for treatment that is within the evidence-based treatment guidelines.

As a reminder, although the oral proceeding has
13:44:59 concluded, written comments will be accepted through Friday, September 15. That's close of business Friday, September 15. Thank you.

We will now adjourn and move upstairs to the third floor for the rest of our agenda, and you are all invited. It is a public meeting, so please join us if you wish. Thank you.

(The proceedings concluded at 1:45 p.m.)

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CERTIFICATE

I HEREBY CERTIFY that the proceedings had upon the foregoing hearing are contained in the shorthand record made by me thereof, and that the foregoing 30 pages constitute a full, true, and correct transcript of said shorthand record, all done to the best of my skill and ability.

DATED at Phoenix, Arizona, this 28th day of August, 2017.

Vicki L. O'Ceallaigh Champion, RPR
Certified Reporter
Certificate No. 50534